



## Community Partnership Application of Intent

Please provide us with the following information. If we need additional information, we will contact you.

**Organization Name** \_\_\_\_\_

**Contact Name Title** \_\_\_\_\_

**Address** \_\_\_\_\_ **City** \_\_\_\_\_ **Zip** \_\_\_\_\_

**Phone** \_\_\_\_\_ **Alternate Phone Number** \_\_\_\_\_

**Fax** \_\_\_\_\_ **Email** \_\_\_\_\_

**Web Address** \_\_\_\_\_

### Organization Description:

### Range of Services (Please select all items that apply)

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Breastfeeding                                   | <input type="checkbox"/> Faith                 | <input type="checkbox"/> Youth Development         |
| <input type="checkbox"/> Caregiver Support                               | <input type="checkbox"/> Family Planning       | <input type="checkbox"/> Legal Services            |
| <input type="checkbox"/> Child Care                                      | <input type="checkbox"/> Family Services       | <input type="checkbox"/> Medi-Cal                  |
| <input type="checkbox"/> Child Protection                                | <input type="checkbox"/> Food- Farmer's Market | <input type="checkbox"/> Medical Center            |
| <input type="checkbox"/> Counseling                                      | <input type="checkbox"/> Food- Food Bank       | <input type="checkbox"/> Mental Health-External    |
| <input type="checkbox"/> Domestic Violence                               | <input type="checkbox"/> Food- Store           | <input type="checkbox"/> Mental Health- Internal   |
| <input type="checkbox"/> Education- Health                               | <input type="checkbox"/> Foster Youth          | <input type="checkbox"/> Mother Mentor             |
| <input type="checkbox"/> Education- Breastfeeding                        | <input type="checkbox"/> Foundation            | <input type="checkbox"/> Parenting                 |
| <input type="checkbox"/> Education- Childbirth                           | <input type="checkbox"/> Health Insurance      | <input type="checkbox"/> Prenatal or Health Care   |
| <input type="checkbox"/> Education- Early                                | <input type="checkbox"/> Hotline               | <input type="checkbox"/> Regional Center           |
| <input type="checkbox"/> Education- Nutrition                            | <input type="checkbox"/> Housing- Resource     | <input type="checkbox"/> School                    |
| <input type="checkbox"/> Education - Parenting                           | <input type="checkbox"/> Housing               | <input type="checkbox"/> Substance Abuse Treatment |
| <input type="checkbox"/> Education- Perinatal                            | <input type="checkbox"/> Transportation        | <input type="checkbox"/> TANF (Welfare)            |
| <input type="checkbox"/> Education- Prenatal                             | <input type="checkbox"/> Immigration           | <input type="checkbox"/> Teen Services             |
| <input type="checkbox"/> Emergency Needs (clothing, food, shelter, etc.) | <input type="checkbox"/> WIC                   | + <input type="checkbox"/> Other _____             |
|  | <input type="checkbox"/> Legal                 |  |

### Eligibility Criteria:



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**Your Organization Referral Method (Email, Fax, Phone) and Frequency (daily, weekly):**

**We are Interested in (Please select all that apply)**

- ☐ Speaking at a Health Education Class
  - ☐ Holding my own class at DHS
  - ☐ Information Table at Prenatal Clinic
  - ☐ DHS Medical Staff Presentations
  - ☐ Partnering on grant writing
  - ☐ Inviting MAMA's Neighborhood DHS Staff to our working groups
  - ☐ Other
- 

**We are creating a directory which will include the information you provide to us. Please check the box(es) next to the statements you agree with below.**

- ☐ Yes, you can share my information with other MAMA'S Neighborhood partners.

The following information can be shared:

- ☐ General contact information
- ☐ MAMA'S Neighborhood referral contact person
- ☐ Range of programs and services

- ☐ No, you cannot share my information with other MAMA'S Neighborhood partners.

- ☐ Yes, I can commit to Quarterly Collaboration MAMA's Neighborhood Meetings

- ☐ No, I am unable to commit to Quarterly MAMA's Neighborhood Collaboration Meetings

I am able to commit to \_\_\_\_\_

- ☐ I want to be on MAMA's Neighborhood Day Planning Committee

**Send application to: MAMA's Neighborhood**  
21840 S Normandie Ave | Torrance, CA 90502  
| Fax 310.222.7215 | [jshorts@dhs.lacounty.gov](mailto:jshorts@dhs.lacounty.gov)

**DIRECT YOUR QUESTIONS ABOUT PARTNERSHIP TO JOCELYN SHORTS**

Phone 310.222.3918 | [jshorts@dhs.lacounty.gov](mailto:jshorts@dhs.lacounty.gov)